Questionnaire Bone Scintigraphy

Would you please hand this form to the assistant before the examination.

Name patient			
Date of birth	Height (cm)	Weight (kg)	MTD

Question	Yes	No
Do you have pain in your bone or joint? Where?	Yes ☐	No ☐
Have you ever had an operation of bone or joint? When? Where?	Yes ☐	No ☐
Have you ever had an injury of bone or joint? When? Where?	Yes ☐	No ☐
Have your ever had a bone fracture? When? Where?	Yes ☐	No ☐
Have you ever had radiation therapy?	Yes ☐	No ☐
Have you ever had chemotherapy?	Yes ☐	No ☐
Do you have toothache? Where?	Yes ☐	No ☐
Have you had a dental treatment/implants recently? Where? When?	Yes ☐	No ☐
Are you pregnant?	Yes ☐	No ☐

In case of prostate cancer: **Gleason score:** **PSA:**

I confirm that I have answered the questions concerning my person to the best of my knowledge. I have been informed about the bone scintigraphy and the therefore needed injection of a radioactive substance. I consent to the conduct of the proposed bone scintigraphy. My questions have been adequately answered during a personal conversation.

Date/Time	Patient's signature or legal guardian's signature	Physician's name and signature

Ärztliche Anamnese

Aktivität	MBq	Uhrzeit
Charge		